Certification for Youth Camps 2015 Regulation Changes

Department of Health and Mental Hygiene

Environmental Health Bureau

Center for Healthy Homes and Community Services

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Baltimore, MD 21202-1608

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Mission Statement

MISSION

- The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION

- The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

Legal Authority/Regulation

- Law: Youth Camp Act:
  Health General Title 14 Subtitle 4
- Regulation: COMAR 10.16.06
  - Updated in 2015
- Regulation: COMAR 10.01.17
  - Update in 2014

COMAR 10.16.06.02, Definitions

- Acceptance letter – (added)
- Acute Illness – (minor)
- Administer Medication – (minor)
- Adult – (change)
- Assistant Counselor – (change)
- Critical violation – (change)

COMAR 10.16.06.02, Definitions

- Day Camp – (minor)
- Emergency medication – (added)
- Personnel Administrator – (added)
- Recreational Activity – (change)
- Self-administer – (minor)
- Youth Camp – (minor)

Minor Regulation Changes

- .05 Random Inspections – (minor)
- .08 Application Procedures and Fees – (minor)
- .17 Hearings – (minor)
- .18 Prohibitions to Operate – (minor)
- .19 Alternative Accreditation – (minor)
- .31 Exclusions for Acute Illness – (minor)
- .36 Water Supply – (minor)
- .37 Sewage Disposal – (minor)
- .38 Toilet Facilities – (minor)
- .46 Fire and Other Hazards – (minor)
- .47 Aquatic Programs – (minor)
- .48 Marksmanship – (minor)
- .49 Archery – (minor)

Minor Regulation Changes

- .50 Horseback Riding – (minor)
- .51 Other Specialized Activities – (minor)
- .52 Trip – (minor)
- .53 Transportation – (minor)

Significant Regulation Changes or Additions

- .03 Local Government – (change)
- .04 State Agency Program – (change)
- .12 Acceptance Letter – (added)
- .13 Post Acceptance Letter – (added)
- .14 Denials – (change)
- .15 Suspensions – (change)
- .21 Background Checks – (change)
- .22 Health Program – (change)
- .23 Health Personnel – (change)
- .24 Health Log – (change)
- .25 Required Reports – (change)
- .26 Report Form – (change)
- .27 Camper's Health Record – (change)

Significant Regulation Changes or Additions

- .28 Electronic Health Records – (change)
- .29 Staff Member/Volunteer Health Records – (change)
- .30 Exclusions for Outbreak – (change)
- .33 Medications – (change)
- .34 Emergency Procedures – (change)
- .35 Child Abuse Prevention and Reporting – (added)
- .42 Food Service – (change)
- .54 Supervision During Routine Activities – (change)

Local Government and State Agencies

- (.03/.04) Process similar to current application process for certified youth camps
- (.03/.04) Will receive renewal applications in 2016
- (.12) Will receive Acceptance Letter in 2015
- (.13) Must post Acceptance Letter in 2015

Denials and Suspensions

- (.14) Denial – Update references and add missing self-assessment or background check for personnel administrator as reason for denial.

- (.15) Suspensions – Update references and add missing background checks as reason for suspension.

.21 Background Checks Personnel Administrator

- DHMH must have the personnel administrator's criminal background results from CJIS
- Use DHMH Authorization Number: 9400019171
- ***DO NOT USE THIS AUTHORIZATION NUMBER FOR OTHER STAFF MEMBERS***

.21 Background Clearance from Child Protective Services

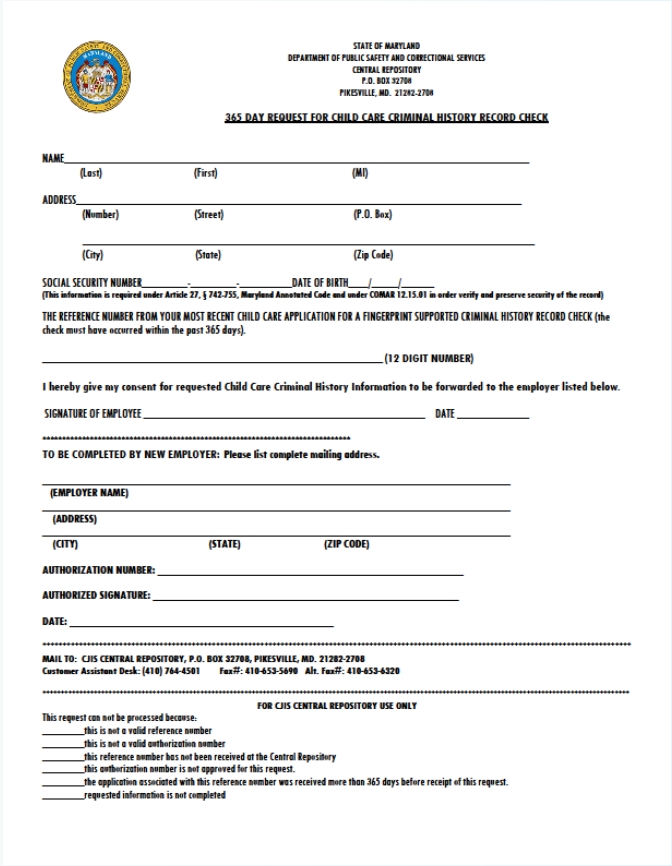
- All employees must complete CPS Release of Information Form (DHR/SSA 1279).

- Personnel Administrator should use the sample form provided which includes the contact information for DHMH-CHHCS.

.21 Reviewing Background Checks and Clearances

- Personnel Administrator must review MD and FBI background checks and CPS background clearance information.
- No hits for something in Regulation .21E.
- If hit for something in Regulation .21F must review accordingly.

365 Day Request



STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CENTRAL REPOSITORY
P.O. BOX 32708
PIKESVILLE, MD. 21282-2708

365 DAY REQUEST FOR CHILD CARE CRIMINAL HISTORY RECORD CHECK

NAME_____
(Last) (First) (MI)

ADDRESS_____
(Number) (Street) (P.O. Box)

_____
(City) (State) (Zip Code)

SOCIAL SECURITY NUMBER_____-_____-_____DATE OF BIRTH____/____/_____
(This information is required under Article 27, § 742-755, Maryland Annotated Code and under COMAR 12.15.01 in order verify and preserve security of the record)

THE REFERENCE NUMBER FROM YOUR MOST RECENT CHILD CARE APPLICATION FOR A FINGERPRINT SUPPORTED CRIMINAL HISTORY RECORD CHECK (the check must have occurred within the past 365 days).

_____(12 DIGIT NUMBER)

I hereby give my consent for requested Child Care Criminal History Information to be forwarded to the employer listed below.

SIGNATURE OF EMPLOYEE _____ DATE _____

****

TO BE COMPLETED BY NEW EMPLOYER: Please list complete mailing address.

_____
(EMPLOYER NAME)
_____
(ADDRESS)
_____
(CITY) (STATE) (ZIP CODE)

AUTHORIZATION NUMBER: _____

AUTHORIZED SIGNATURE: _____

DATE: _____

****

MAIL TO: CJIS CENTRAL REPOSITORY, P.O. BOX 32708, PIKESVILLE, MD. 21282-2708
Customer Assistant Desk: (410) 764-4501 Fax#: 410-653-5690 Alt. Fax#: 410-653-6320

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FOR CJIS CENTRAL REPOSITORY USE ONLY

This request can not be processed because:
_____this is not a valid reference number
_____this is not a valid authorization number
_____this reference number has not been received at the Central Repository
_____this authorization number is not approved for this request.
_____the application associated with this reference number was received more than 365 days before receipt of this request.
_____requested information is not completed

- Use for individuals who were fingerprinted for child care within last year
- Does not require fingerprints
- No charge

Health Program

CPR/First Aid

COMAR 10.16.06.23

- Minimum of 2 Adults
  - Certification Issued by National Organization
- On Duty at All Times
  - From 1st camper arrival to last camper pick up
- Field Trips
  - One with trip and one at camp if campers stay behind

Health Program

Health Log

COMAR 10.16.06.24

See Sample Health Log

Must Include:

1. Date
2. Name of Camper
3. Ailment
4. Treatment Prescribed
5. Name or Initials of Person Administering Care

Must Be:

1. On Lined Paper
2. Kept Confidential
3. In Locked Compartment
4. Available to Department
5. Retained for 3 years
6. Recorded in Ink
7. No Skipped Lines
8. Have Sequentially Numbered Pages

Health Program

Required Reports

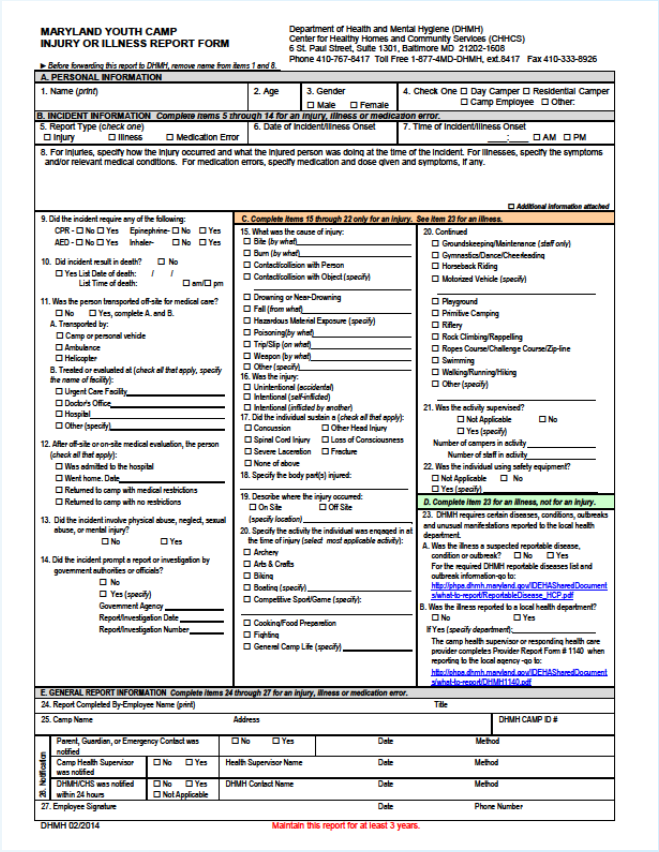
COMAR 10.16.06.25

- Use Chart to determine when and to whom the report should be made
- Always record incidents in health log
- Accident with no apparent injury as well
- Health Supervisor & Director Review & Document Findings

Health Program

Injury/Illness Report

COMAR 10.16.06.26



MARYLAND YOUTH CAMP
INJURY OR ILLNESS REPORT FORM

Department of Health and Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301, Baltimore MD 21202-1608
Phone 410-767-8417 Toll Free 1-877-4MD-DHMH, ext.8417 Fax 410-333-8926

► *Before forwarding this report to DHMH, remove name from items 1 and 8.*

A. PERSONAL INFORMATION

1. Name (print) | 2. Age | 3. Gender ☐ Male ☐ Female | 4. Check One ☐ Day Camper ☐ Residential Camper ☐ Camp Employee ☐ Other:

B. INCIDENT INFORMATION *Complete items 5 through 14 for an injury, illness or medication error.*

5. Report Type (check one) ☐ Injury ☐ Illness ☐ Medication Error | 6. Date of Incident/Illness Onset | 7. Time of Incident/Illness Onset ☐ AM ☐ PM

8. For injuries, specify how the injury occurred and what the injured person was doing at the time of the incident. For illnesses, specify the symptoms and/or relevant medical conditions. For medication errors, specify medication and dose given and symptoms, if any.

☐ *Additional information attached*

9. Did the incident require any of the following:
CPR - ☐ No ☐ Yes Epinephrine- ☐ No ☐ Yes
AED - ☐ No ☐ Yes Inhaler- ☐ No ☐ Yes

10. Did incident result in death? ☐ No ☐ Yes List Date of death: / / List Time of death: ☐ am/☐ pm

11. Was the person transported off-site for medical care? ☐ No ☐ Yes, complete A. and B.
A. Transported by:
☐ Camp or personal vehicle
☐ Ambulance
☐ Helicopter
B. Treated or evaluated at (*check all that apply, specify the name of facility*):
☐ Urgent Care Facility
☐ Doctor's Office
☐ Hospital
☐ Other (specify)

12. After off-site or on-site medical evaluation, the person (*check all that apply*):
☐ Was admitted to the hospital
☐ Went home. Date
☐ Returned to camp with medical restrictions
☐ Returned to camp with no restrictions

13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury?
☐ No ☐ Yes

14. Did the incident prompt a report or investigation by government authorities or officials?
☐ No
☐ Yes (specify)
Government Agency
Report/Investigation Date
Report/Investigation Number

C. Complete items 15 through 22 only for an injury. See item 23 for an illness.

15. What was the cause of injury:
☐ Bite (by what)
☐ Burn (by what)
☐ Contact/collision with Person
☐ Contact/collision with Object (specify)
☐ Drowning or Near-Drowning
☐ Fall (from what)
☐ Hazardous Material Exposure (specify)
☐ Poisoning/by what)
☐ Trip/Slip (on what)
☐ Weapon (by what)
☐ Other (specify)

16. Was the injury:
☐ Unintentional (accidental)
☐ Intentional (self-inflicted)
☐ Intentional (*inflicted by another*)

17. Did the individual sustain a (*check all that apply*):
☐ Concussion ☐ Other Head Injury
☐ Spinal Cord Injury ☐ Loss of Consciousness
☐ Severe Laceration ☐ Fracture
☐ None of above

18. Specify the body part(s) injured:

19. Describe where the injury occurred:
☐ On Site ☐ Off Site
(specify location)

20. Specify the activity the individual was engaged in at the time of injury (*select most applicable activity*):
☐ Archery
☐ Arts & Crafts
☐ Biking
☐ Boating (specify)
☐ Competitive Sport/Game (specify):
☐ Cooking/Food Preparation
☐ Fishing
☐ General Camp Life (specify)

20. Continued
☐ Groundskeeping/Maintenance (staff only)
☐ Gymnastics/Dance/Cheerleading
☐ Horseback Riding
☐ Motorized Vehicle (specify)
☐ Playground
☐ Primitive Camping
☐ Riflery
☐ Rock Climbing/Rappelling
☐ Ropes Course/Challenge Course/Zip-line
☐ Swimming
☐ Walking/Running/Hiking
☐ Other (specify)

21. Was the activity supervised?
☐ Not Applicable ☐ No
☐ Yes (specify)
Number of campers in activity
Number of staff in activity

22. Was the individual using safety equipment?
☐ Not Applicable ☐ No
☐ Yes (specify)

D. Complete item 23 for an illness, not for an injury.

23. DHMH requires certain diseases, conditions, outbreaks and unusual manifestations reported to the local health department.
A. Was the illness a suspected reportable disease, condition or outbreak? ☐ No ☐ Yes
For the required DHMH reportable diseases list and outbreak information-go to:
http://phpa.dhmh.maryland.gov/IDEHASharedDocuments/what-to-report/ReportableDisease_HCP.pdf
B. Was the illness reported to a local health department?
☐ No ☐ Yes
If Yes (*specify department*)
The camp health supervisor or responding health care provider completes Provider Report Form # 1140 when reporting to the local agency -go to:
http://phpa.dhmh.maryland.gov/IDEHASharedDocuments/what-to-report/DHMH1140.pdf

E. GENERAL REPORT INFORMATION *Complete items 24 through 27 for an injury, illness or medication error.*

24. Report Completed By-Employee Name (print) | Title

25. Camp Name | Address | DHMH CAMP ID #

Notification

Parent, Guardian, or Emergency Contact was notified	☐ No ☐ Yes		Date	Method
Camp Health Supervisor was notified	☐ No ☐ Yes	Health Supervisor Name	Date	Method
DHMH/CHS was notified within 24 hours	☐ No ☐ Yes ☐ Not Applicable	DHMH Contact Name	Date	Method

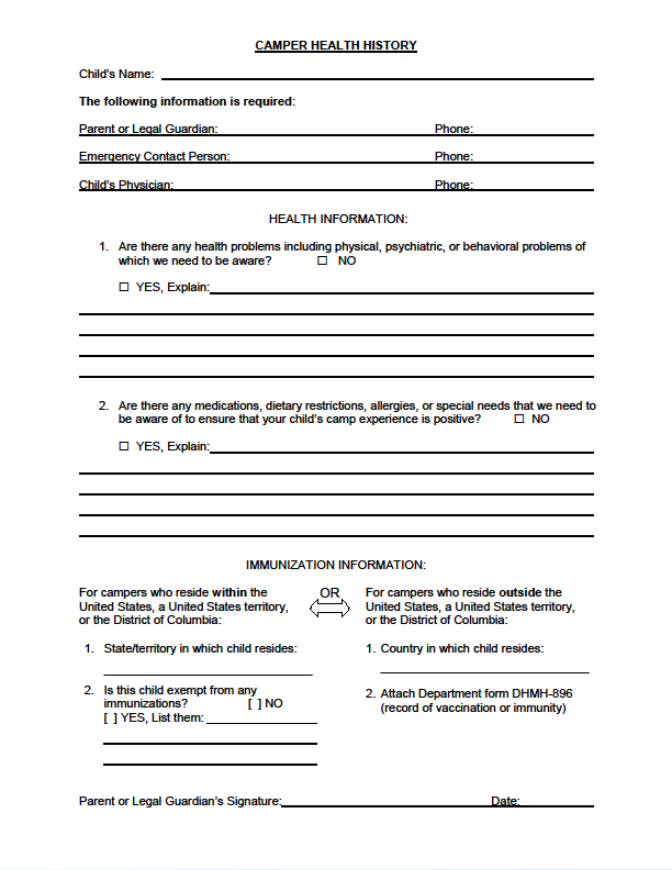
27. Employee Signature | Date | Phone Number

DHMH 02/2014 Maintain this report for at least 3 years.

Health Program

Health Records

COMAR 10.16.06.27



CAMPER HEALTH HISTORY

Child's Name: _____

The following information is required:

Parent or Legal Guardian: _____ Phone: _____

Emergency Contact Person: _____ Phone: _____

Child's Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive? ☐ NO

   ☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

For campers who reside **within** the United States, a United States territory, or the District of Columbia:

1. State/territory in which child resides: _____
2. Is this child exempt from any immunizations? [ ] NO
   [ ] YES, List them: _____

OR

For campers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. Country in which child resides: _____
2. Attach Department form DHMH-896 (record of vaccination or immunity)

Parent or Legal Guardian's Signature: _____ Date: _____

.28 Electronic Health Records

- EHR may be used in place of:
  - A health log;
  - A camper health record;
  - A staff or volunteer health record;
  - A medication administration authorization form;
  - A medication administration form;
  - A Medication disposition form; or
  - When an operator uses standing orders for medication administration, a parent or guardian consent form

.28 Electronic Health Records

- Operate shall ensure that the EHR is:
  - Capturing the same required information as the paper record being replaced;
  - Password protected;
  - Accessed only by authorized staff members;
  - Permanent and will not be deleted;
  - Capable of tracking staff member use of the system and producing an auditable record;
  - Maintained in a confidential manner;
  - Available at all times for review by the Department upon request; and
  - Retained for a period of 3 years

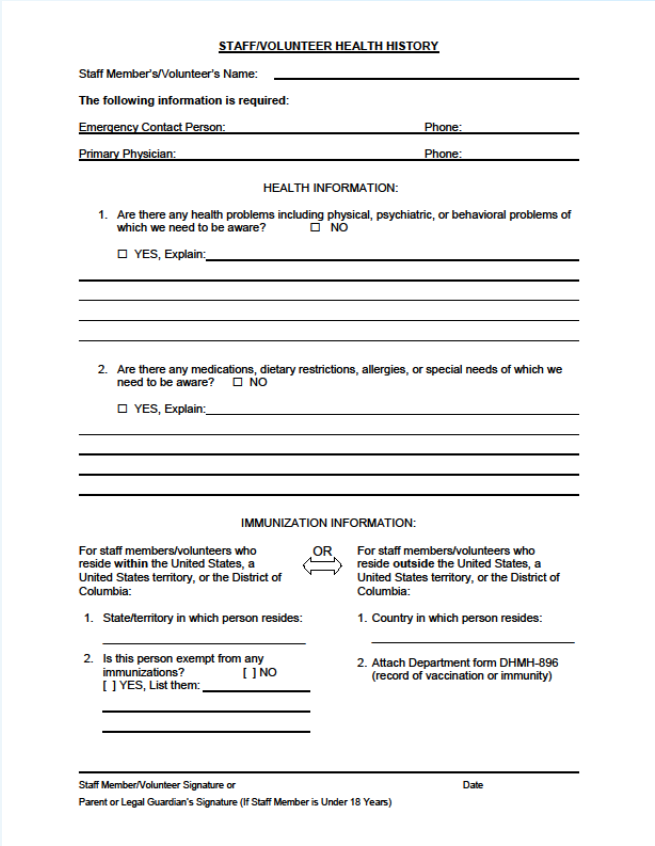
.28 Electronic Health Records

- If the EHR is unavailable for any reason, the camp operator shall:
  - Provide paper health log
  - Record injuries, etc. in paper health log
  - Transcribe info from paper log to EHR
  - Annotate paper health log that transcription occurred
  - Retain paper health log for 3 years
  - Provide an alternative means to access the EHR

Health Program

Health Records

COMAR 10.16.06.29



STAFF/VOLUNTEER HEALTH HISTORY

Staff Member's/Volunteer's Name: _____

The following information is required:

Emergency Contact Person: _____ Phone: _____

Primary Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

For staff members/volunteers who reside **within** the United States, a United States territory, or the District of Columbia:

1. State/territory in which person resides: _____
2. Is this person exempt from any immunizations? [ ] NO
   [ ] YES, List them: _____

OR

For staff members/volunteers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. Country in which person resides: _____
2. Attach Department form DHMH-896 (record of vaccination or immunity)

Staff Member/Volunteer Signature or Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years) _____ Date

.30 Exclusion During Vaccine-Preventable Disease Outbreak

- Cannot admit camper who is not vaccinated or who does not have natural immunity to the disease

- Cannot work or volunteer who is not vaccinated or who does not have natural immunity to the disease

Health Program

Medications

COMAR 10.16.06.33

- Add written medication procedures to Health Program
- Covers Prescription and Nonprescription Medicine
- Self-administration vs. Staff Administration
  - Medication administration training acceptable to the Department
- Prescriptive Order for All Medication – DHMH form
- Parental Consent Documented
- Authorization for self-administration and self carry
- Emergency medication
- Return to parent or destroy, document

.34 Emergency Procedures

- Added requirement for a section in the plan on monitoring for adverse weather conditions

- Added requirement for procedures

.35 Child Abuse Prevention and Reporting

- Handout on writing Child Abuse Prevention and Reporting Program

- Self-assessment tool for developing a Child Abuse Prevention and Reporting Program

.42 Food Service

•Notify parent in writing of camp's policy on storage of a lunch brought from home

•If camp allows potentially hazardous food, (COMAR 10.15.03) lunch must be refrigerated at a temp. of 41°F or below

•Cold Food – at or below 41°F

•Hot Food – at or above 135°F

.54 Supervision During Routine Activities

•G. An assistant counselor under the direction of an adult may supervise, for up to 30 minutes, no more than five campers without an adult supervisor present.

Staff

- Training
  - Document staff training for the following:
    - Health Program
      - Including Medication Administration
    - Emergency Plan
    - Trip Safety Plan
    - Transportation Safety Plan
    - Specialized Activities Safety Plans
    - Child Abuse Report Requirements
- CPR and First Aid certification
  - Document current CPR/first aid
  - Ensure that at least 2 adults with CPR/FA are on duty during camp

Questions